State of Colorado

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - NURSING HOME CARE

The State of Colorado hereby finds and assures that the rates for long term care facilities are reasonable and adequate to meet the costs that efficiently and economically operated facilities must incur. A facility is considered to be operated efficiently and economically when it complies with the State and Federal licensing and certification requirement, applicable State reporting requirements at a patient per diem cost equal to or less than the maximum reasonable allowable cost ceilings, fair rental allowance payments and other payments standards specified in section I and II of this Attachment 4.19-D.

METHODS

I. A. Cost Reporting and Auditing - All facilities are required to report costs on the accrual basis of accounting. Governmental facilities operation on a cash basis may use the cash method for cost reporting subject to adjustments for capital expenditures. All long term care providers must submit two uniform six-month cost reports, both of which are audited. The first six-month report (interim report) is desk audited and an interim rate is established; the second six-month report is field audited (along with the interim report) and a final rate is established. The interim rate is revised, if necessary.

1. All facilities with costs $5.00 or more above the administrative and health care ceilings established July 1 of each year shall be audited once every third year. A rate calculation based on those costs reported on the cost report shall be performed yearly.

B. Effective August 1, 1987, the following methods shall govern cost reporting and auditing:

1. All facilities are required to report costs on the accrual basis of accounting. Governmental facilities operation on a cash basis may use the cash method for cost reporting subject to adjustments for capital expenditures. All long term care providers must submit uniform cost reports which are audited. During State Fiscal Year 1988, providers will convert from the submission of six-month cost reporting schedule to a 12-month cost reporting schedule as indicated by the following conversion schedule.

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2. Conversion Schedule

Facility Fiscal Year End Date	First 12-Month Cost Report	Last Interim to Set a Rate
07/31/86	Period of 08/01/86-07/31/87	08/01/86-01/31/87
08/31/86	Period of 09/01/86-08/31/87	09/01/86-02/28/87
09/30/86	Period of 10/01/86-09/30/87	10/01/86-03/31/87
10/31/86	Period of 11/01/86-10/31/87	11/01/86-04/30/87
11/30/86	Period of 12/01/86-11/30/87	12/01/86-05/31/87
12/31/86	Period of 01/01/87-12/31/87	01/01/87-06/30/87

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Facility Fiscal Year End Date	First 12-Month Cost Report	Last Interim to Set A Rate
01/31/87	Period of 02/01/87-01/31/88	02/01/87-07/31/87
02/28/87	Period of 03/01/87-02/28/88	03/01/87-08/31/87
03/31/87	Period of 04/01/87-03/31/88	04/01/87-09/30/87
04/30/87	Period of 05/01/87-04/30/88	05/01/87-10/31/87
05/31/87	Period of 06/01/87-05/31/88	06/01/87-11/30/87
06/30/87	Period of 07/01/87-06/30/88	07/01/87-12/31/87

3. Once all providers have been cycled through this conversion schedule, all future cost reports shall be filed for a 12-month period of time with the last day of the cost report corresponding with the last day of the providers fiscal year end.

4. The fiscal year for all providers shall remain the same as on record with the Department when these regulations are made effective. There are two exceptions to this rule.

   a. Providers seeking to coordinate their fiscal year with the fiscal year end they have established with the IRS.

   b. Subchapter "S" corporations are required by federal tax law to have a fiscal year end of December 31. The first new tax fiscal year end for these providers shall be coordinated with the period ending December 31, 1987.

5. Rate Effective Dates

   a. Beginning with the first 12-month cost report filed by a provider, the rate effective date shall be the first day of the third calendar month following the last day of the cost report.

   b. The rate effective dates for last interim cost report as described in the above conversion schedule shall be effective on the first day of the month in which the 60th day falls after the cost report is submitted by the provider to the State.

   Beginning with rates on and after July 1, 1988 the rate effective dates for State-owned and administered ICF/MR's ~~shall~~ be the first day of the cost report filed by facilities.

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II. Computation of Rate - Computation of the reimbursement rate for each nursing facility classification, excluding the State-owned and operated* ICF/MR's, is calculated as follows:

A. Maximum reasonable allowable cost - once each year a listing of audited costs is compiled which lists the number of patients in each nursing facility and allowable audited costs for the facility. The nursing facilities are grouped by class and listed from the facility with the lowest allowable audited cost to the highest. In determining the rates beginning on July 1 each year, the State uses the data on the Medicaid populations in each facility within each class on May 1, as well as the most current cost information submitted on or before May 2.

1. For health care services and raw food costs, the maximum reasonable cost is set at the 125th percentile weighted average of allowable costs for all Medicaid patients residing in Class I, Class II, and Class IV nursing facilities.

"Health care services" means the following categories of reasonable, necessary, and patient-related support services. No service shall be considered a health care service unless it is listed below:

The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, nurse aides, medical records librarians, social workers, and activity personnel. These personnel must be appropriately licensed and/or certified, as applicable, although nurse aides may work in any facility for up to 4 months before becoming certified;

Non-prescription drugs ordered by a physician which are included in the per diem rate;

Consultant fees for nursing, medical records, patient activities, social workers, pharmacies, physicians and therapies. Consultants must be appropriately licensed and/or certified, as applicable, and professionally qualified in the field for which they are consulting;

Purchases, rentals, and repair expenses of health care equipment, and supplies used for health care services such as nursing care, medical records, social services, activity and recreational therapy;

* The reimbursement methodology for the State-owned and operated ICF/MR's is described in Section III of the Method portion of this Attachment 4.19-D.

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Depreciation and interest for major health care equipment purchases;

Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles to the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs.

Photocopying expenses related to health care services (e.g., residents' medical records), as documented by appropriate logs;

Salaries, fees, or other expenses related to work performed by a facility owner or manager who has a medical or nursing credential;

Malpractice insurance for the health care personnel listed above;

Medical director fees;

Therapies and services provided by an individual qualified to provide these services under Federal Medicare/Medicaid regulations including:

Utilization review;
Dental care, when required by federal law;
Audiology;
Psychology and mental health services;
Physical therapy;
Recreational therapy; and
Occupational therapy.

Food cost is the cost of raw food, and shall not include the costs of real or personal property, staff, preparation, or other items related to the food program.

2. For administration, property, and room and board costs (excluding raw food, land buildings, and fixed equipment costs), the maximum reasonable cost is set at the 120th percentile weighted average of actual allowable costs for all Medicaid patients residing in Class I, Class II, and Class IV nursing facilities.

"Administration costs" means the following categories of reasonable, necessary, and patient-related costs:

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The salaries, payroll taxes, worker compensation payments, training and other employee benefits of the administrator, assistant administrator, bookkeeper, secretarial, other clerical help, janitorial and plant staff. Staff who perform duties in both administrative and health care services shall maintain contemporaneous time records in order to properly allocate their salaries between cost centers;

Any portion of other staff costs directly attributable to administration;

Advertising;

Recruitment costs and staff want ads for all personnel;

Public relations;

Office supplies;

Telephone costs;

Purchased services: management and home office fees for administrative services; accounting fees, legal fees; computer services;

Payroll taxes;

Licenses, liability insurance, non-medical transportation, training for administrative personnel, dues for professional associations and organizations;

All travel of facility staff, except that required for transporting residents to activities or for medical purposes;

All insurance except for malpractice insurance for health care personnel. Insurance on vans, whether owned or leased, is an administrative cost;

Facility membership fees in trade groups or professional organizations;

Miscellaneous general and administrative costs;

Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles. However, such costs shall be considered health care services to the extent that the motor vehicles are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs;

Purchases, rentals, repairs, betterments and improvements of equipment utilized in administration;

Allowable audited interest not covered by the fair rental allowance or related to the property costs listed below;

All other reasonable, necessary, and patient-related costs which are not specifically set forth in the description of "health care services" above, and which are not property, room and board, food, or capital-related assets.

Property costs include:

Depreciation costs of non-fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care);

Rental costs of non-fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care);

Property taxes;

Property insurance;

Interest on loans associated with property costs covered in this section;

Repairs, betterments and improvements to property not covered by the fair rental allowance;

Repair, maintenance, betterments or improvement costs to property covered by the fair rental allowance payment which are to be expensed as required by state regulations;

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Room and board includes:

Dietary other than raw food;

Laundry and linen;

Housekeeping;

Plant operation and maintenance; and

Repairs, betterments and improvements to equipment related to room and board services.

3. LIMITATIONS ON GROWTH OF ALLOWABLE COSTS: With respect to all rates effective on or after July 1, 1997, for each class I and class V facility, any increase in allowable (i.e., reimbursed) administrative costs shall not exceed six percent (6%) per year and any increase in allowable health care services costs shall not exceed eight percent (8%) per year. These limitations shall apply to the costs which are used in annually calculating the weighted average cost ceilings for all class I nursing facilities, and also to the costs which are allowed when calculating an individual rate change for a class I or V facility. However, after application of these limitations, the allowable costs for an individual facility may be increased through the payment of a fluctuating cost allowance and/or administrative cost incentive allowance, if in accordance with the methodology stated elsewhere in the state plan.

LIMITATION ON MEDICARE PART A COSTS: For all rates effective on or after July 1, 1997, the Department shall limit the Medicare Part A ancillary costs (hereafter referred to as "Part A costs") which are allowed in calculating the Medicaid per diem rate for each class I and class V nursing facility. For all rates effective on 7/1/97, the Department shall include whatever level of Part A costs the Department allowed from the most recent Medicare cost report submitted by the facility to the Department prior to July 1, 1997. This level of Part A costs shall be used as the base figure in limiting subsequent Part A cost increases. Any subsequent increase shall not exceed the increase over the corresponding time period in the Consumer Price Index ("medical care" component in the "U.S. City Average") published for all urban consumers (the "CPI-U") by the United States Department of Labor, Bureau of Labor Statistics.

LIMITATION ON MEDICARE PART B COSTS: For all rates effective on or after July 1, 1997, only those Medicare Part B costs which the Department determines to be reasonable shall be included in calculating the allowable per diem Medicaid reimbursement for class I and V nursing facilities.

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B. Effective January 1, 1995, the administrative incentive allowance shall be calculated at twelve and one-half percent (12.5%) for the Class I and Class V Nursing Facility vendors for the difference between the ceiling and provider's costs for administration, property, and room and board cost per patient day that is less than the maximum reasonable cost. The administrative incentive allowance shall be calculated at twelve and one-half percent (12.5%) of the difference between the facility's audited cost and the maximum reasonable cost, not to exceed twelve percent (12%) of the maximum reasonable cost.

Class II and the privately owned Class IV Nursing Facility providers shall continue to receive the incentive allowance for administration, property and room and board cost per patient day. The allowance is calculated at twenty-five percent (25%) of the difference between the audited costs and the maximum reasonable cost, not to exceed twelve percent (12%) of the maximum reasonable cost. Therefore, Class II and IV facilities will not be eligible to participate in the Quality of Care Incentive Payment program.

Maximum Reasonable Cost
- Audited cost per patient day for administration, property and room and board.

Difference

Difference X 12.5% except for Class II and IV.

No incentive allowance may be earned on health care services or raw food costs.

NOTE: No incentive allowance will be paid for services rendered from August 1, 1986 to November 30, 1986.

An incentive allowance will be paid for services rendered from December 1, 1986 to December 4, 1986. No incentive allowance will be paid to Class I and V facilities for services rendered from December 5, 1986 to April 30, 1987. Should the Department determine at the conclusion of State Fiscal Year 1987 there is available appropriation to pay the incentive allowance for this period, then the incentive payments shall be restored to the extent of those available appropriations.

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No incentive allowance will be paid to Class II and Privately owned Class IV facilities for services rendered from January 21, 1987 through June 30, 1987. Should the Department determine at the conclusion of State Fiscal Year 1987 there is available appropriation to pay the incentive allowance for this period, then the incentive payments shall be restored to the extent of those available appropriations.

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